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The NYS OMH Partnership Model:

Collaborating to establish a continuum of supports and services

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NYS Medicaid Managed Care

- Mental Health and Substance Use Services previously carved out of managed care were moved in
  10/1/15 in NYC
  7/1/16 Rest of State
- All Plans needed to qualify to manage newly carved in behavioral health services
- Types of Managed Care Plans
  - Mainstream Managed Care Plan
  - Health and Recovery Plans (HARPs)
  - HIV SNP
  - Managed Long Term Care (MLTC) (Partial Capitation)
    - The Medicaid benefit for Medicare duals can be managed in an MLTC plan if the person meets the criteria of needing 120 days of LTC Services

Adult Behavioral Health Transition to Managed Care: Mental Health Services

- Existing State Plan Benefits Moving into Medicaid Managed Care:
  - Inpatient Psychiatric Services*
  - Mental Health Clinic*
  - Partial Hospitalization
  - Personalized Recovery Oriented Services (PROS)
  - Assertive Community Treatment (ACT)
  - Continuing Day Treatment (CDT)
  - Comprehensive Psychiatric Emergency Program (CPEP)
  - Intensive Psychiatric Rehabilitation Treatment (IPRT)
- 1115 Demonstration Services Only:
  - Crisis Intervention
  - Other Licensed Mental Health Practitioner Services (off-site services out of mental health clinic)

How are HARPs different than other Medicaid Managed Care Plans?

- HARPs specialize in serving people with severe behavioral health conditions
- HARPs cover additional services called Adult Behavioral Health Home and Community Based Services (BH HCBS)
- Some HARP enrollees will be eligible for Adult BH HCBS
- A Care Manager, providers and Plans will work together to assist HARP members

Adult Behavioral Health Home and Community Based Services (BH HCBS)

Maintain Housing. Live Independently.

- Psychosocial Rehabilitation
- Community Psychiatric Support and Treatment
- Habilitation
- Non-Medical Transportation for needed community services

Return to School. Find a Job.

- Education Support Services
- Pre-Vocational Services
- Transitional Employment
- Intensive Supported Employment
- Ongoing Supported Employment

Manage Stress. Prevent Crises.

- Short-Term Crisis Respite
- Intensive Crisis Respite

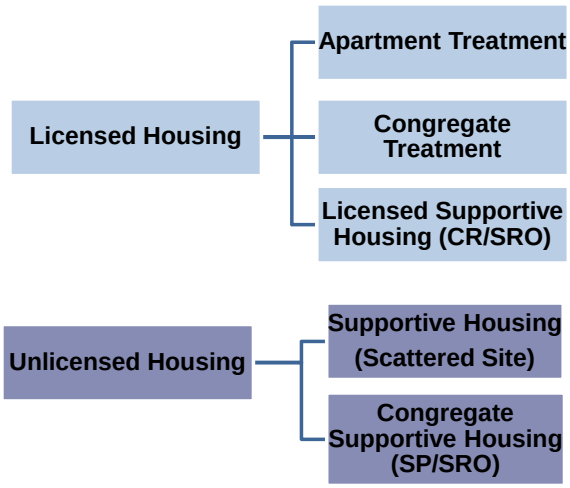
Get Help from People who Have Been There and Other Significant Supporters

- Peer Support Services
- Family Support and Training

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NYS OMH Housing's Full Continuum of Supports



Total Beds*	# Occupied*
5,400	4,525
5,048	4,588
3,436	3,141
24,316	21,301

*As of 12/31/2017

Total Beds: 37,804
Total Occupied: 33,555

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Trends in New York State Psychiatric Centers

NYS State PCs (Bronx, Buffalo, Capital District, Creedmoor, Elmira, Greater Binghamton, Hutchings, Hudson River, Kingsboro, Manhattan, Mohawk Valley, NYS Psychiatric Institute, Pilgrim, Rochester, Rockland, South Beach, St. Lawrence)	**CY 2008**	**CY 2018**
Census*	3,879	2,291
# (Percentage) of Patients with ≥1 Year LOS	2,154 (55.53%)	1,223 (53.38%)
# (Percentage) of Patients Age ≥65 Years	380 (9.80%)	408 (17.81%)

**Reflects census dates of 6/30/2008 and 6/30/2018*
Excludes Sexual Offender Treatment Programs and Regional Forensic Units

Transitioning Individuals from State PCs to Community Settings

Goal: Make living in the most integrated setting possible a reality for individuals with Serious Mental Illness by building partnerships to support collaboration between home care, behavioral health providers and OMH housing.

Population: Individuals living at State Psychiatric Centers (PCs) and surrounding Congregate Residences. Individuals are not nursing home eligible; however have significant medical needs and other co-occurring chronic conditions that make home health aide and personal care necessary for community living.

Components: OMH State Operations partners with home care agencies for multi-disciplinary assessment and development of individualized plans of care to support transition and maintenance in community. State-operated Mobile Integration Teams (MITs) partner with home care to provide individualized support to transition candidates and home health aides providing services. OMH Housing collaborates with home care, MIT Teams and other in-reach BH providers for intense support following transition and developing maintenance plan for permanent community living.

State Operated Mobile Integration Teams

Goal: Prevent long hospital stays in IMDs and support the transition of individuals with long stays back into the community.

Design: Provide clinical interventions and support necessary for successful community transition and progress with community integration and recovery.

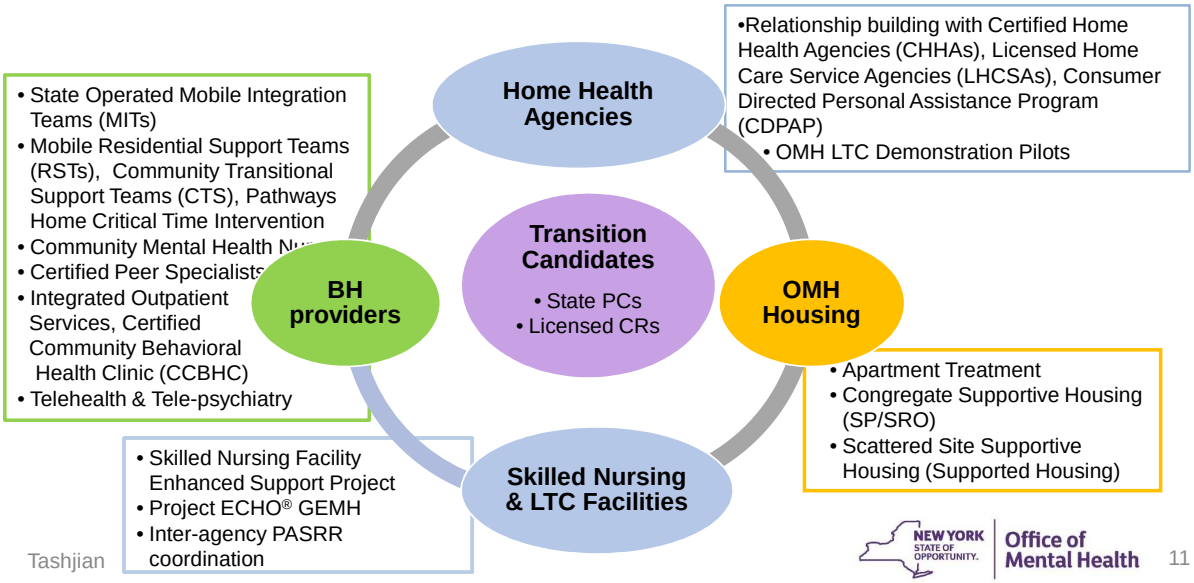
- Stabilize crisis situations
- Reduce environmental stress
- Reduce ER and Inpatient presentations

Typical Staffing: Includes nursing, social work, rehabilitation counselors, peers, and psychiatric consultation.

Results to Data

- Assisted 1,295 people to transition from IMD into the community.
  - Of those 1,295 people
    - 114 individuals had a length of stay (LOS) between 1-2 years
    - 62 individuals had a LOS between 2-5 years
    - 5 individuals had a LOS between 5-10 years
    - 24 individuals had a LOS >10 years
- January-November 2017—19 MITs
  - Served 5,272 people
  - Made 62,094 contacts
  - For those enrolled in MIT Services:
    - 6.4% had psychiatric hospitalization
    - 5.6% had ER visits without hospitalization
    - Most frequent services:
      - Outreach/engagement
      - Therapeutic support
      - Skill building
      - Community linkage

OMH Partnership Model



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Skilled Nursing Facility (SNF) Project Components

- Model to address SMI population that is nursing home eligible
- Provision of enhanced supports to the SNF
- Psychiatric Consultations through Project ECHO® (The Extension for Community Healthcare Outcomes) GEMH (Geriatric Mental Health in Long Term Care):
  - A program providing regularly scheduled teleECHO™ sessions that brings together expert interdisciplinary specialists, LTC and Behavioral Health providers using web-based videoconferencing technology
- Training for SNF Staff
- Build Collaborations with Community Partners/Critical Stakeholders:
  - ❖ SNFs
  - ❖ Article 28 Hospitals
  - ❖ County Directors of Community Services
  - ❖ Field Office
  - ❖ DOH-Office of Long Term Care

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Skilled Nursing Facility Project and Enhanced Supports: Outcomes and Goals

240 Total Discharges to date

- 2016=87
- 2017=90
- 2018=63

Short Term

- Increase timely discharge of individuals in state-operated PCs
- Support the SNFs to meet the psychiatric needs of individuals accepted from OMH facilities during the transition period

Long Term

- Use the ECHO® GEMH model to help SNFs build and sustain capacity

Staffing

- Project Manager
- Regional Coordinators
- Facility Teams
    - 14 Adult Civil Facilities,
    - 24 Community Mental Health Nurses (close collaboration with SWs and Discharge Planning Teams, Mobile Integration Teams (MIT) (back up coverage)
- ECHO® GEMH Specialist Team/University of Rochester (available via contract)

Project ECHO® GEMH Project

Project ECHO® GEMH for Long Term Care (LTC):

- An education, consultation & training infrastructure offering clinical and non-clinical staff at nursing homes an opportunity for virtual “grand rounds” teleconferencing with an interdisciplinary specialist team to review complex cases
- Case presentations are collaborations between SNF and OMH Discharge Teams at State PCs
- Primary intervention chosen for the by the Finger Lakes Performing Provider System for New York State Delivery System Reform Incentive Payment Program (DSRIP), Project 3.a.v Behavioral Interventions Paradigm in Skilled Nursing Facilities (SNF)
- Led by Rochester Regional Health System (RRHS) and UR Medicine

Progress Report:

- Roll out to 30 SNFs downstate: June 8, 2017
- Bi-Weekly Virtual Clinics in progress
- 79 Participants in the first Virtual Clinic

OMH Reinvestment in Community Based Housing

As PC transitional beds (RCCAs, TLRs) are closed, the savings is reinvested in the form of scattered-site Supportive Housing beds:

- 2 SH community beds per 1 PC bed
- The SFY 2017-18 budget included 280 beds in PC catchment areas where reductions were made

Recommendations for CMS Support in Streamlining Transitions for Individuals Living with SMI

Federal Medicaid reimbursement for:

Streamlined Transitions to the Community-

- On-site multi-disciplinary assessments and individualized transitional care planning for individuals residing in IMD settings in cases where discharge is imminent

Addressing Social Determinants of Health

- Supportive Housing- building modifications to support aging in place and universal design
- On-site case management support provided by OMH Housing

Increased Access to Mental Health Expertise

- On-site Community Mental Health Nurses at SNFs
- Psychiatric consultation through virtual clinics, such TeleECHO™, for SNFs and home care agencies